



## MEDIVAC EMERGENCY INFORMATION BRIEF SHEET

The information required on this form is necessary in order to ensure that proper preparation can be completed to adequately care for the patient. You must ensure that all information is passed to the MEDIVAC helicopter and to the receiving medical facility. There are no medical facilities on Kaho`olawe, therefore, in the event of a medical emergency, you will be evacuated from Kaho`olawe subject to availability of the Medivac helicopter.

**THIS FORM MUST BE RENEWED EVERY SIX MONTHS**

**Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Organization: \_\_\_\_\_

Age: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Medical and/or Physical Limitations: \_\_\_\_\_

Physician Statement Restriction(s): Y N Date of Restriction(s): \_\_\_\_\_

Nature of Restriction(s): \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Sex: M F Blood Type (If Known): \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_

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## ACCIDENT / INJURY FIRST RESPONSE

Reporting Party: \_\_\_\_\_

Date and Time  
of Report: \_\_\_\_\_

Type of Accident / Injury: \_\_\_\_\_

Date/Time/  
Location of  
Injury: \_\_\_\_\_